2005 BASIC PLAN COMPARISON
SUMMARY OF BENEFITS

	Blue Shield HMO	PERS Choice PPO		PERSCare PPO	
2005 PREMIUMS✚					
1 Party	$355.03	$366.08		$613.79	
2 Party	$710.06	$732.16		$1,227.58	
Family	$923.08	$951.81		$1,595.85	
CALENDAR YEAR DEDUCTIBLE		*(Not transferable between plans)*			
Individual	None	$500		$500	
Family	None	$1,000		$1,000	
HOSPITAL ADMISSION DEDUCTIBLE		**PPO**	**non-PPO**	**PPO**	**non-PPO**
Per Admission	No charge	None	None	$250	$250
EMERGENCY ROOM DEDUCTIBLE/COPAY		**PPO**	**non-PPO**	**PPO**	**non-PPO**
Per Visit (waived if admitted to hospital as inpatient or for observation as outpatient)	$50	$50	$50	$50	$50
MAXIMUM CALENDAR YEAR COPAY		**PPO**	**non-PPO**	**PPO**	**non-PPO**
Member	None	$3,000	None	$2,000	None
Family	None	$6,000	None	$4,000	None
LIFETIME MAXIMUM BENEFIT	None	$2,000,000 *(per individual)*		None	
MEDICAL BENEFITS		**PPO**	**non-PPO**	**PPO**	**non-PPO**
Hospital -- In-Patient and Outpatient	No charge	20%	40%	10%†	40%†
Physician Office Visits	$10 visit ($30 visit for specialists if self-referred)	$20 copay‡	40%	$20 copay‡	40%
Other Physician Services	No charge	20%	40%	10%	40%
Preventive Care	$10 visit/immunization	No charge‡	40%	No charge‡	40%
Diagnostic X-ray and Laboratory	No charge	20%	40%	10%	40%
Hearing Aid Services *($1,000 maximum in 36-month period for hearing aids)*	$10 visit/exam	20%	40%	10%	40%
Ambulance Services	No charge	20%	20%	20%	20%
Emergency Services	$50 visit *(Waived if admitted to hospital)*	20% *($50 deductible per visit for covered ER charges--waived if admitted to hospital)*	20%	10%	10%
Chiropractic	Not covered	20% *(Combined benefit for Chiropractic/Acupuncture--15 visits per calendar year)*	40%	10% *(Combined benefit for Chiropractic/Acupuncture--20 visits per calendar year)*	40%

MEDICAL BENEFITS	Blue Shield HMO	PERS Choice PPO		PERSCare PPO	
		PPO	non-PPO	PPO	non-PPO
Outpatient Speech Therapy	$10 visit	20%	40%	10%	40%
		($5,000 lifetime maximum)			
Durable Medical Equipment	No charge	20%	40%	10%	40%
		($3,000 per calendar year--precertification required)		*(precertification required)*	
Hospice Care	No charge	20%	20%	10%	10%
		($10,000 lifetime maximum)			
Physical Therapy	$10 visit	20%*	40%*	10%	40%
Occupational Therapy	$10 visit	20%*	20%*	20%	20%
Mental Health					
(Includes mental health parity provisions)					
Inpatient	No charge	20%	40%	10%	40%
	(up to 30 days per calendar year--no limits for severe mental illness or serious emotional disturbances of a child)	*(Up to 20 days per calendar year)*		*(Up to 30 days per calendar year--12,000 lifetime maximum for any combination of inpatient and outpatient benefits)*	
Outpatient	$20 visit (up to 20 visits per calendar year for other than severe mental illness or serious emotional disturbance of a child)	20% *(up to 24 visits per calendar year for other than severe mental illness or serious emotional disturbance of a child--precertiication required for licensed clinical psychologists and master's level therapists only)*	40%	10% *(up to 30 visits per calendar year for other than severe mental illness or serious emotional disturbance of a child--precertification required for licensed clinical psyhologists and master's level therapists only)*	40%
	$10 visit *(no limits for severe mental illness or serious emotional disturbances of a child)*				
Substance Abuse					
Inpatient	No charge *(limited to acute medical detoxification)*	20% *(up to 20 days per calendar year - $12,000 lifetime maximum for any combination of inpatient and outpatient benefit)*	40%	10%** *(up to 15 days per calendar year)*	40%**
Outpatient	$10 visit *(up to 20 visits per calendar year)*	20% *(up to 24 visits per calendar year--precertification required for licensed clinical psychologists and master's level therapists only)*	40%	10% *(up to 30 visits per calendar year--precertification required for licensed clinical psychologists and master's level therapists only)*	40%

	Blue Shield HMO	PERS Choice PPO		PERSCare PPO	
MEDICAL BENEFITS		**PPO**	**non-PPO**	**PPO**	**non-PPO**
Home Health Care *(custodial care not covered)*	No charge	20% *(up to $6,000 per calendar year)*	40%	10% *(up to 100 visits per calendar year)*	40%
Skilled Nursing Facility	No charge *(up to 100 days per calendar year)*	20% *(First 10 days -- precertification required)*	40%	10% *(First 10 days -- precertification required)*	40%
		30% *(next 90 days -- precertification required)*	40%	20% *(next 170 days -- precertification required)*	40%
PRESCRIPTION DRUG BENEFITS					
Retail Pharmacy Program* **	30-day supply	Up to a 30-day supply for short-term use		Up to a 34-day supply for short-term use	
	$ 5 Generic $15 Formulary Brand $45 Non-Formulary ($30 if medical necessity approved for non-formulary)	$ 5 Generic $15 Formulary Brand $45 Non-Formulary Brand ($30 if medical necessity approved for non-formulary)		$ 5 Generic $15 Formulary Brand $45 Non-Formulary Brand ($30 if medical necessity approved for non-formulary)	
Mail Service Program	Up to a 90-day supply	Up to a 90-day supply		Up to a 90-day supply	
	$10 Generic $25 Formulary Brand $75 Non-Formulary ($45 if medical necessity approved for non-formulary)	$10 Generic $25 Formulary Brand $75 Non-Formulary Brand ($45 if medical necessity approved for non-formulary)		$10 Generic $25 Formulary Brand $75 Non-Formulary Brand ($45 if medical necessity approved for non-formulary)	
	($1,000 maximum calendar year copayment per person for mail order prescriptions)				

✚ *Premiums apply to State members only. Public Agency premiums are regionally priced.*

† Services received are not subject to the calendar year deductible, but are subject to the $250 hospital admission deductible.

‡ Services received from a Preferred Provider are not subject to the calendar year deductible.

** A $3,500 calendar year maximum for combined physical therapy and occupational therapy applies for PERS Choice.*

*** A $250 inpatient hospital admission applies for PERSCare.*

**** Mail order copayment after second fill at retail on maintenance medications applies for PERS Choice and PERSCare.*
(Maintenance medication is medication taken longer than 60 days for chronic conditions.)

Note for PERSCare and PERS Choice PPO plans:

- ***Reimbursement for non-preferred professional charges will be at 60% of the Blue Cross Prudent Buyer fee schedule.***
- ***Deductibles and copayments will not carry over from one plan to the other.***

This is only a summary of benefits offered. Please refer to each plan's Evidence of Coverage booklet for the exact terms and conditions of coverage.